Clinical Section

ORTHOPTICS

By

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Orthoptics is one of the newer specialties in the field of Medicine and deserves more consideration from the profession than it has received.

When a child squints, that is, turns an eye in or out usually more noticeable when he is tired or on looking at something close, the cause should be immediately investigated. I am not speaking of short periodic squints in babies but of those where there is a definite tendency to always use one eye at a time. The end results of squint are always the same—amblyopia in the squinting eye and a marked deformity to which children, especially girls, become very sensitive when they reach school age.

What can be done for these cases—fortunately, a great deal. When a child is presented for treatment the procedure is to first record his angle of deviation—10, 25, 45 or 60 degrees, as the case may be. The motility of the eye is now tested by bringing the recti and oblique muscles into action, thus making sure that you are dealing with a concomitant and not a paralytic condition — a fundus examination, a test of vision in each eye separately and refraction follows — preferably under atropin. But suppose the vision in the deviating eye even with glasses is found to be low, say under 25 per cent—it may be reduced to the counting of fingers at three or four feet—consideration must be given to the number of years the child has squinted. If the condition has existed for six years or more, establishment of good central vision may prove difficult but should always be attempted provided the patient can attend the clinics regularly.

The methods used to restore vision are atropin in the good eye or occlusion of it, thus forcing the defaulting one to work. Worth used atropin but the process is slow and on the whole I have not found it satisfactory. Occlusion is better but it must be properly done. A shade, a ground glass inserted in the spectacles, or a postage stamp stuck to the lense, have all been tried but are totally inadequate. The child when unobserved will "peek" or take his glasses off and the last stage is no better than the first.

The only sure method of occlusion is the adhesive patch. It should be two inches wide and extend from the bridge of the nose up over the eyebrow and down to the malar prominence. While this patch is on the vision in the deviating eye should be tested at least once a week and the improvement in vision recorded. In a young squinter the vision can be quickly stepped up from 1/10 to 6/10 or better. He is now ready for orthoptic training.

In this there are many instruments on the market that will help you. Worth's amblyoscope was the original and all the later devices are essentially modifications of it.

The child sits before the instrument—say a rotoscope. He looks through a pair of binoculars at a set of two pictures that attached to a calibrated scale can be made to converge or diverge as required. The pictures are approximately eight inches from the eyes and so the binoculars are fitted with plus five spheres making accommodation unnecessary. A broad diaphram extends outward from a point midway between the binoculars to the center of the picture scale so that the right eye cannot see the picture or target in front of the left eye and in the same way the left eye cannot see the right target.

The targets are made in pairs. On one there is the picture of a bird, on the other a cage. With these the first and simplest tests are made. If the child has, say, an internal squint of twenty-five degrees, the targets are moved into this angle and he is asked what he sees. Frequently he will say that he sees the bird—if that picture happens to be in front of the better eye. Hold a sheet of paper in front of this eye and ask him to look again. This time he sees a cage but no bird. On removing the paper he will see the bird again but the cage has disappeared. He is suppressing. On some instruments the targets are illuminated by small electric lights either of which can be made to "flash." With the child looking at the bird under steady light the bulb over the cage is started flashing. This is introducing something that cannot be easily be ignored. He sees the bird, then the cage, finally both at the same time. He has now mastered the first step in true binocular vision. He is next asked if the bird is in the cage. If not, the pictures are converged or diverged a little until the picture is complete. His true angle of deviation is now read off from the scale and recorded.

Fusion, the second grade of binocular vision, is then tried for. The targets used have similar outlines. For instance two men are seen. Heads and bodies are the same on both targets but in the first picture the man is minus a leg, and in the second he has an umbrella in his hand. When fusion is achieved, the child sees one man with two legs and an umbrella in his hand. Divergence is now attempted, if it is an internal squint we are dealing with, by separating the targets thus stimulating the external recti to overcome the pull of the interni.

The third grade of binocular vision is known as stereopsis or depth perception. For this test another set of targets are used. On each is a circle with radiating spokes which meet at a smaller circle—off centre. When the child looks through the instrument he receives the impression of looking not at flat surfaces but into a funnel. The targets are next moved out if he has an internal squint or in, for an external till a point marked zero on the scale is reached and if he states that he still sees a funnel his visual axes must be parallel, that is, his eyes are straight.

One is often asked when orthoptic training should be started. Generally speaking just as soon as the child can talk and take an interest in pictures, but the refraction should be done the moment a permanent deviation is noticed. Worth reports refracting a child 14 weeks old.

Unfortunately, orthoptics will not cure all squinters. There are some cases where the squinting eye has become so blind that co-operation with the other for binocular vision and parallelism is impossible. Then there are others where a convergence excess or insufficiency is so marked that even after prolonged training his angle is only partially reduced. It is here where surgery is indicated for even if binocular vision cannot be obtained the cosmetic effect will be very gratifying both to the child and to the parents.

A great many operations have been devised and the choice must remain with the surgeon. Obviously, if you are sure you are dealing with excess convergence, the thing to do is a recession of one or both internal recti. If on the other hand you feel that the interni are exercising only a normal amount of "pull" an advancement of the external rectus or recti is indicated. I am not in favor of tenotomies because one can never tell where the tenotomized muscle will reattach itself. Whichever operation is adopted, orthopic training should be resumed to stabilize the eyes in their new position.

At present there are over sixty children enrolled at the Orthoptic Clinic at the Children's Hospital, and the class is growing rapidly. In Miss Corke, we have a full time Orthoptist who received her training at the Children's Hospital, Birmingham, England. The clinic is free to those who are unable to pay.

Naturally in an article of this kind one cannot go too deeply into details. My object is simply to bring before the profession what the hospital is doing and thereby making it possible for more children to avail themselves of this service.

In closing, I would like to emphasize three points. First, there is need of the profession and through them the public becoming squint conscious. Second, squinters should be seen early before amblyopia has set in, and thirdly, as the training of these children is a tedious, time-consuming task it had best be done by a qualified orthoptist.

Special Articles and Association Notes

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Executive Meeting

Minutes of a meeting of the Executive of the Manitoba Medical Association held in the Medical Arts Club on Tuesday, June 7th, 1938, at 6.00 p.m.

Present.

Dr. C. W. Burns (Chairman)	Dr. E. W. Stewart
Dr. C. W. MacCharles	Dr. S. G. Herbert
Dr. Digby Wheeler	Dr. W. G. Campbell
Dr. O. C. Trainor	Dr. Geo. Clingan
Dr. E. S. Moorhead	Dr. W. S. Peters
Dr. A. S. Kobrinsky	Dr. E. K. Cunningham
	Dr. J. D. Fraser.

Following dinner, the meeting was called to order by the President and the minutes of the last meeting held on April 8th, 1938, were read by the secretary.

It was moved by Dr. Digby Wheeler, seconded by Dr. O. C. Trainor: THAT these minutes as read be adopted. —Carried.

Re. Pregnancy Survey.

In reply to letter addressed to the General Secretary of the Canadian Medical Association on April 13th, the secretary read communication received from Dr. Routley under date of April 19th, advising that the whole matter of making grants will be studied and dealt with at the next meeting of their Executive Committee.

Report of Committee on Workmen's Compensation Board.

Dr. Burns reported that they had endeavored to arrange an appointment with Major Newcombe, but had not been able to arrange a suitable time.

Health Insurance in Toronto.

Dr. MacCharles reviewed briefly reprint of an article received from Dr. Hannah describing a co-operative plan of providing medical services which is being tried in Toronto.

Dr. MacCharles advised that this plan has been in operation only for a short time and no conclusions could be arrived at from it. Dr. Kobrinsky suggested that copies of a summary of this plan should be sent to all the members of the Executive unless it was available from some other source.

Group Hospital Insurance.

The secretary referred to a reprint of the Community Hospital Plan in operation in Kingston: copy is on file.

The secretary also reported that Mr. Rufus Roren, Director of the Committee of Hospital Services of the American Hospital Association, had addressed a meeting of medical men at the Winnipeg General Hospital on Friday, May 13th, 1938, and explained how the plan had worked in various American cities.

Single Men on Farms.

The secretary reviewed the correspondence in connection with this matter and advised that we were waiting to hear further from Mr. MacNamara in this connection.

Saskatchewan Hospital Cases.

Letter was written to Dr. Lindsay, Registrar of the College of Physicians and Surgeons of Saskatchewan, and reply which was received had been forwarded to Dr. Waugh but no further comments have as yet been received from Dr. Waugh.

Report of Programme Committee.

Dr. Wheeler read a tentative programme with the names of the various speakers so far obtained, and discussion followed regarding times and dates for the different activities.

Letter from Dr. J. W. Simpson.

A lengthy letter was read from Dr. Simpson of Gretna pointing out that men in the country could not get in to the meetings on account of not being able to obtain locum tenums. It was suggested that senior interns be allowed to go out. Dr. Campbell, however, pointed out that this was against the ruling of the College of Physicians and Surgeons and that only registered men could go. He advised that as a rule they had names of various men looking for locum tenums and that in many cases a man could be supplied.

It was moved by Dr. S. G. Herbert, seconded by Dr. E. W. Stewart: THAT a notice be put in the *Review* asking men wishing to do locum tenums to write and advise the secretary. —Carried.

Report of Chairman of Committee on Sociology.

Dr. Moorhead read the introduction to the Survey of Illness amongst the Unemployed and their families in the City of Winnipeg, copy of which is on file.

It was moved by Dr. E. S. Moorhead, seconded by Dr. Digby Wheeler: THAT this introduction be adopted. —Carried.

Appointment of Member on Canadian Medical Association Executive.

Dr. Moorhead spoke in connection with this and advised that he had been the representative appointed for the past three years and felt that he has acted long enough in this capacity and would like to see someone else appointed.

Following discussion, it was moved by Dr. W. S. Peters, seconded by Dr. O. C. Trainor: THAT this Executive thank Dr. Moorhead for the splendid way in which he has represented this Association on the Canadian Medical Association Executive. —Carried.

It was moved by Dr. Digby Wheeler, seconded by Dr. W. G. Campbell: THAT Dr. O. C. Trainor be nominated as representative of this Association on the Canadian Medical Association Executive. —Carried.

It was moved by Dr. Digby Wheeler, seconded by Dr. W. G. Campbell: THAT Dr. W. S. Peters be nominated to the Nominating Committee for the Canadian Medical Association. —Carried.

Report of Federation Committee.

Dr. McKenty read report which was submitted by him to this Executive on April 8th, 1938. He stated that the report now being submitted should be accompanied by a covering letter, draft of which Dr. McKenty read to the meeting as an introduction to the report. He then read the mimeographed report, copy of which was handed around to all members present, and each clause was discussed and alterations suggested.

It was moved by Dr. F. D. McKenty, seconded by Dr. W. G. Campbell: THAT this report as amended be approved. —Carried.

It was the feeling of the Federation Committee that this report be put in the hands of the members of Council in attendance at the meeting.

It was suggested that Dr. McKenty present this to the Council, or if not, Dr. Peters or some other delegate should do so.

It was moved by Dr. Trainor, seconded by Dr. Clingan: THAT Dr. Moorhead be instructed to present this report to the meeting of the Executive Committee.

It was moved by Dr. Clingan, seconded by Dr. W. G. Campbell: THAT the delegates to the Council be instructed to present this Federation report to the meeting of the Council.

It was moved by Dr. Wheeler, seconded by Dr. Trainor: THAT no application for admission as a division of the Canadian Medical Association be submitted by the Manitoba Medical Association to the Annual Meeting of the Canadian Medical Association at Halifax on June 20th, 1938. —Carried.

Medical Secretaries' Conference.

The secretary advised that he had received a communication from Dr. Routley under date of April 18th, advising that it had been planned to have a first meeting of the secretaries of the various Provincial Associations to be held at Halifax on June 20th in the form of a round table discussion.

It was the opinion of the Executive that Dr. C. W. MacCharles should be present at this meeting as it was the first meeting of the provincial secretaries.

King George V. Silver Jubilee Cancer Fund.

The secretary reviewed the correspondence in connection with this problem including a letter which had been received since the last Executive meeting from Dr. G. S. Young, Chairman of the Executive Committee of the Canadian Medical Association, under date of May 2nd, 1938.

This matter was discussed fully and is recorded in the minute book.

Proposal for Federation

WITH

Canadian Medical Association

INTRODUCTION

The Manitoba Medical Association have taken a position of caution and criticism regarding the proposed Federation of the Canadian Medical Association, and this has been maintained to a point at which there is danger of it being regarded as an attitude of obstruction. On this account it is necessary that the Manitoba Medical Association should make its position perfectly clear.

The Manitoba Medical Association has never been unsympathetic towards the idea of union between the Provincial body and the Canadian Medical Association. But the explanation of its position has been stated in a number of reports and can be briefly outlined. It is that a Canadian Medical Association that is to have the moral authority of the Canadian profession, must be such as will enlist the voluntary support of the great majority of its members, and that in order to find such support it is imperative that its organization embody two conditions that are insepar-

able and of equal importance. It must be as fully representative of the membership as possible, and there must be direct responsibility of the members of the administration to their constituents. Given these essentials, the organization can grow along the right lines.

The Manitoba Medical Association has, from the beginning of the movement, consistently urged the full application of these principles. A study of the constitutions of South Africa and Australia shows that they have been carefully observed in spite of geographic difficulties comparable to those in Canada.

The Canadian Medical Association if it is to have any purpose, must be granted some power. Such power can only come from the limitation of the power of the Provincial Associations. Unless the extent of such power is defined and its exercise controlled by an effectively representative and responsible body, the Manitoba Medical Association considers that it would be inadvisable to enter a contract which makes no provision for withdrawal.

REPORT OF THE MANITOBA MEDICAL ASSOCIATION COMMITTEE ON FEDERATION

Submitted to the Executive of the Manitoba Medical Association and Adopted on April 8, 1938

The Committee on Federation of the Manitoba Medical Association in accordance with the instructions of the Executive to report upon the new draft for a constitution for a federated Canadian Medical Association beg to submit the following:—

No copies of the proposed constitution have been available. The only information regarding it that the Committee has obtained was from the reading of selected passages by the General Secretary at the recent informal meeting with the Manitoba Medical Association Executive. This was not sufficient to warrant any definite report upon the details. Your Committee can therefore only reiterate the conclusions and resolutions already reached by the Manitoba Medical Association upon the Federation Proposal.

The Manitoba Medical Association has declared itself in favor of a Federation that meets certain requirements. These may be briefly summarized as follows:

The function of the federated body should be limited to the fields in which the need for centralized action can be clearly shown, and these fields should be defined.

The mandatory body must be fully representative of the whole medical profession.

The general policies of the federated body should be subject to discussion by the general profession and approval or otherwise registered through the constituent representatives.

Avenues for the prompt expression of the views of any section of the membership should be provided and kept open, and information regarding the proceedings should be fully and regularly supplied to the membership.

The membership of the mandatory body should be as small as is consistent with full representation. (The present General Council is much too large).

Active membership should be conditional upon attendance at the sessions.

Active members should be representative of their constituents and instructed in advance of the session upon the matters to be decided.

An accredited substitute should be named for each active member. (See procedure of B.M.A.). (In order to secure the above conditions it may be necessary for the federated body, or its constituent sections, to assume a portion of the necessary expense).

The Executive must also be fully representative. The responsibility of each member of the Executive should be directly to the constituent association which he represents.

Each member of the Executive should be instructed by his association (or division) before each session of the Executive, upon the matters in the agenda which concern it, and he should report to it the decisions which have been reached.

The general aim of the foregoing provisions is to secure a federated body that will be to the fullest possible degree representative of and responsive to its membership. Under such conditions the responsible management would be at all times aware of the degree of professional support it enlisted, and leadership could be assured and progressive.

It is recognized that a fully representative procedure is of necessity slow and troublesome, and that it would entail some publicity of the business of the Association. However, rapid decisions in matters of policy are rarely necessary, and the secrecy of the Board of Directors of an industrial corporation should be needless and out of place in a body representing a liberal profession. Only the moral support involved in a thoroughly representative procedure can enable the management to speak with authority for the whole profession. Your Committee firmly believe that the ultimate value of any Federation depends upon the degree to which such character is maintained.

COMMITTEE ON FEDERATION REPORT

Submitted to the Executive of the Manitoba Medical Association and Adopted on June 7, 1938

In accordance with the instructions of the Manitoba Medical Association Executive, the Committee on Federation has examined the amended "Constitution and By-Laws of the Canadian

Medical Association, Applicable to Divisions'' as published in the May issue of the C.M.A. *Journal*, in order to ascertain the degree to which the articles of the Constitution correspond with the views of the Manitoba Medical Association.

Article I—Title: No comment.

Article II—Objects: As set forth these are as follows:

> "1. The promotion of health and the prevention of disease.
> 2. The improvement of medical services however rendered.
> 3. The maintenance of the integrity and honor of the medical profession.
> 4. The performance of such other lawful things as are incidental or conducive to the welfare of the public and of the medical and allied professions."

The objects of the Manitoba Medical Association as expressed in its Constitution are as follows:

> "The objects of this association shall be the promotion of the medical and allied sciences; the maintenance of the honor and interests of the medical profession and of the members thereof, collectively and individually; the co-operation of the members of the association for their mutual assistance and support in all matters affecting them in their professional capacity; the advancement of public welfare."

The objects of the two Associations thus completely overlap. It would be possible for both Associations to be engaged with the same objective at the same time, as occurred in British Columbia.

Article XIV of the Constitution states that each province shall have control of its own affairs. But such provision fails completely to solve the difficulty as the affairs of the province are nowhere defined in the constitution. The meaning of this phrase ''control of its own affairs'' should be stated.

An illustration of the possible difficulty that might arise occurs in connection with the development of a scheme of Dominion Health Insurance. This might fittingly be the task of the Canadian Medical Association. But the application of any scheme and the manner of its administration would be of acute concern to the profession of the province.

Other possibilities of overlapping might be suggested but this example alone seems sufficient ground for defining more closely the respective spheres of the two bodies. In the case of the Medical Association of South Africa (British Medical Association),[1] and especially the Federal Council of the British Medical Association in Australia,[2] the objects of the Associations are defined explicitly and in detail.

We recommend that the respective spheres of activity of the provincial and Dominion associations be defined and that the following be added to Article II—

> Without in any way defining, limiting or restricting the objects of the Canadian Medical Association or its powers or duties as conferred by its Memorandum of Association or these Regulations or by law, the Canadian Medical Association shall perform the following duties:
>
> (a) It shall be the medium for communicating with the Dominion Government on behalf of the Divisions collectively and when required so to do by any Division it may in its discretion be a medium for communicating with the Government of the Province in which such Division is situated in any matter affecting the medical profession in that Province.
>
> (b) It may consider any matter affecting the medical profession in Canada and may act in connection therewith on behalf of the Divisions collectively.

Articles III, IV, V, VI, VII: No comment.

Article VIII, Section C: ''and such other officers as may be appointed by the Executive Committee''—should be altered to—''and such other officers as may be appointed by the General Council, but in an emergency in the case of an unexpired term the Executive may appoint a temporary officer to complete the term subject to ratification by the next meeting of Council.''

Article IX: To increase the efficiency of the General Council, it is suggested that the minimum provincial elective representation to be reduced[3] from five to two; that membership be conditional upon the attendance of the members or accredited substitutes at the sessions;[4] that the term of membership should be three years;[5] and that the transportation[6] expenses[7] of members should be met jointly by the associations or pooled. Similar provisions exist in the constitutions of the South Africa and Australian Associations where the general conditions are similar.

The British Medical Association,[8] the Medical Association of South Africa (British Medical Association),[9] the British Medical Association in Australia,[10] and also Ontario[11] agree in appointment of delegates by divisions, instructions of delegates and reports of delegates to divisions. We recommend that these principles should be embodied in the constitution of the Canadian Medical Association and in the constitution of each Provincial Association.

Article IX, Sections D and E: Elected representatives only should vote. Chairmen and Secretaries of Committees and of Sections are not elected representatives. They should be present at Council only to make the necessary reports.

Article X: The arrangement of Standing Committees might be revised. Their fields could be better integrated with the main activities of the profession, so as to prevent overlapping or isolation. For instance, the Executive Committee might be the co-ordinating body for a small number of main Standing Committees covering the whole field of activity of the association and subcommittees might be formed from the personnel of the main committees according to the nature of the problems involved.

Regional representatives or appointees should be named by the region or division concerned.

Article XI: According to this provision, the Council has the duty of raising the funds of the Association but not the direction of their expenditure. We suggest that the following be added:

"The general funds of the association shall be expended for the upkeep of the work connected with it and the payment of emoluments, if any, as directed by the General Council, and the estimated expenditures for the current year shall be approved by the Council."[12]

Articles XII and XIII: No comment.

Article XIII, Section 2: The notice for amendment of Constitution is too short for this country, and the time should be extended to four months.

Article XIV: (See Article II).

By-Laws:

1 and 2: No comment.

Chapter 2, Section 8: No comment.

Chapter 3: No comment.

Chapter 4 and 5: No comment.

Chapter 6, Section 1, 2 and 3: With regard to provisions for election of members of the Executive: The provision for the election of members of Executive by General Council was fitting for the Canadian Medical Association as an independent voluntary body when first organized. At the present time with fully developed provincial associations which it is proposed to federate, the method seems unnecessarily involved and open to criticism on the technical ground that it is not fully representative in that the election is by the General Council rather than the body represented. If the provincial body can elect a member of the Nominating Committee it would be simpler to elect directly its representative on the Executive without the intervention of a Nominating Committee.

We recommend that the members of the Executive Committee should be elected directly by the Divisions.

Chapter 6, Section 2, Sub-section 2: Re. allotment of provincial representatives on Executive Committee: The proposed representation on the Executive from the various provinces is compared with the membership in the Canadian Medical Association for 1937 in the following table. The membership totals may be altered in 1938.

Province	Membership (1937)	Representation
British Columbia	368	1
Alberta	536	1
Saskatchewan	219	1
Manitoba	165	1
Ontario	1,617	3
Quebec	347	3
New Brunswick	134	1
Nova Scotia	237	1
Prince Edward Island	29	1
	3,652	13

There is plainly an inequality of distribution which is difficult to understand. Manitoba with 165 members has one representative, while Alberta with 536 members has only one representative. Quebec with about one-fifth of the membership of Ontario, has the same number of representatives, namely three.

Chapter 7, Section 4: The Honorary Treasurer should be requested to submit an estimate of receipts and expenditures for the next year to General Council at the [13]Annual Meeting.[14]

Chapter 8, Section 3: In addition to the functions specified the General Council should determine the general[15] policies[16] of the Association and these should be embodied in a series of considered decisions and published in a handbook.[17]

REFERENCES

1. Memorandum and Articles of Association and By-Laws of the Medical Association of South Africa (British Medical Association)—pages 3, 4 and 5.
2. Memorandum and Articles of Association and By-Laws of the Federal Council of the British Medical Association in Australia—pages 5, 6, 7 and 8.
3. Memorandum and Articles of Association and By-Laws of the Medical Association of South Africa (British Medical Association)—By-Laws, Chapter 5, Paragraph 26 A, page 27.

   Members of the Association elected by the respective Branches for three years calculated as laid down in By-Law 28 (b) after nomination by voting papers sent to all Members of each Branch in the proportion of one in the case of a Branch with fifty Members, or under, and in the case of larger Branches one for each additional fifty Members or portion thereof, provided that such portion exceeds twenty-five.
4. Memorandum and Articles of Association and By-Laws of the British Medical Association—By-Laws, Chapter 43 (1), page 60.

   Each Constituency shall elect a Member or Members of the Association (no such Member being the Representative or Deputy-Representative of any other Constituency) who (or one of whom in such order of precedence as may be fixed by the Constituency at the time of the election) shall act as Deputy in the place of any Representative of that Constituency at any Representative Meeting in the event of that Representative being unable or unwilling to attend such Meeting, and any such Deputy shall, for the purposes of such Meeting, be the Representative of the Constituency so electing him.
5. Memorandum and Articles of Association and By-Laws of the Medical Association of South Africa (British Medical Association)—By-Laws, Chapter V, Paragraph 28 A, page 28.

   A general election of Members of Council shall be held as aforesaid triennially—each elected Member shall hold office for a period of three years.
6. Memorandum and Articles of Association and By-Laws of the Medical Association of South Africa (British Medical Association)—Article X, page 19.

   The out of pocket expenses of members of the Council attending Meetings of the Council within the Union of South Africa may be defrayed out of Branch Funds of the Association.

7. Memorandum and Articles of Association and By-Laws of the Federal Council of the British Medical Association in Australia — Article 49, page 20.

   Subject to the provisions of Clause 4 of the Memorandum of Association members of the Federal Council and of the Executive Committee may be paid out of the funds of the Federal Council such sums of money by way of travelling or other out-of-pocket expenses incurred in connection with the performance of their duties as such Members as may from time to time be determined by By-Law.

8. British Medical Association Annual Handbook—page 68.

   Duties of Representative: In speaking and voting at Representative Meetings, Representatives must have regard, and so far as may be conform, to the preponderance of opinion of the members of their Constituencies so far as such opinion is known to them.

9. Memorandum and Articles of Association and By-Laws of the Medical Association of South Africa (British Medical Association).

10. Memorandum and Articles of Association and By-Laws of the Federal Council of the British Medical Association in Australia—Articles 8 and 25, pages 13, 15 and 16.

11. Reports and Business Programme for the Annual Meeting of the Council of the Ontario Medical Association, May 3rd, 1938—Article 16, Section 2, Clause D, page 48.

    Delegates and representatives from Ontario on the Canadian Medical Association bodies shall receive instructions from the Directors and Council of the Ontario Medical Association and shall report back to the Ontario Medical Association Council.

12. Memorandum and Articles of Association and By-Laws of the Medical Association of South Africa (British Medical Association)—By-Laws, Chapter IX, page 33.

    The general funds of the Association shall be expended for the upkeep of the work connected with it and the payment of emoluments, if any.

13. Memorandum and Articles of Association and By-Laws of the British Medical Association—Article XIV, page 33.

    Financial and Other Reports and Audit: The Council shall annually prepare a Balance Sheet and Financial Statement of the Association for the past year, an Estimate of the probable income and expenditure of the Association for the coming year, and a Report of the general state and proceedings of the Association for the past year to be presented to the Annual Representative Meeting. Such Balance Sheet and Statement shall be audited by a professional Accountant, and a copy of the same as audited and also a copy of such Estimate and Report shall be sent to the Secretary of every Branch and Division, and published in the "Journal" not less than two months before the said Meeting.

14. Memorandum and Articles of Association and By-Laws of the Medical Association of South Africa (British Medical Association)—Article XI, page 19.

    This is the same as reference 13.

15. Memorandum and Articles of Association and By-Laws of the British Medical Association—Article VI, page 26.

    Subject to the provisions of any Statute, the general control and direction of the policy and affairs of the Association shall be vested in a body of Representatives styled "the Representative Body."

16. Memorandum and Articles of Association and By-Laws of the Medical Association of South Africa (British Medical Association)—Article VI, Paragraphs 30 and 31, page 15.

    Subject to the provisions of any Statute and the provisions of the Agreement referred to in Clause 2 hereof, the general control and direction of the policy and affairs of the Association shall be vested in the Federal Council of the Association. It shall be the duty of the Council to carry into execution Resolutions passed by a General Meeting and administer the affairs of the Association in accordance with the Memorandum of Association and the Regulations and By-Laws, and the Council shall exercise such powers and do such acts and things as may be exercised or done by the Association, and are not by the provisions of any Statute or of the Regulations or the by-laws directed to be exercised or done by a General Meeting.

17. British Medical Association—Annual Handbook—Decisions of Representative Body as to Questions of Policy, pages 85 - 144.

ANNUAL MEETING OF MANITOBA MEDICAL ASSOCIATION

The Annual Meeting of the Manitoba Medical Association will be held in Winnipeg, September 22nd, 23rd and 24th.

The Programme Committee have already made tentative arrangements for the clinical sessions. The Canadian Medical Association has kindly arranged to send two speakers from Eastern Canada and one from the United States: Dr. A. T. Bazin of Montreal, Dr. K. A. MacKenzie of Halifax, and Dr. L. H. Newburgh of the University of Michigan, Ann Arbor, Michigan.

DR. JOHN FARRELL WOOD

Dr. John Farrell Wood of Manitou died at his home on May 7th. He was born in St. Jean Baptiste, Man., but grew up on his father's farm in the Miami district. He graduated in Medicine in 1914 from the Manitoba Medical College, and in the fall of that year enlisted for active service with the R.A.M.C. He served in the war areas of Gallipoli, Egypt, Mesopotamia and France, and received decorations for his services. At the time of his death he held the position of Medical Officer of the Manitoba Mounted Rifles, holding the rank of Major. On his return from overseas Dr. Wood entered into partnership at Manitou with Dr. I. Davidson and later took over the entire practice. He was the Medical Health Officer of the Municipality of Pembina and of Manitou, took an interest in the sports organizations of the town and was an ardent golfer. He was a member of the executive committee of the Manitoba Medical Association representing the Southern District Medical Society. He is survived by his widow and one daughter.

The pall-bearers at his funeral were members of the Manitoba Mounted Rifles from Portage la Prairie. Dr. Wood was a loyal friend and faithful comrade.

LAWN BOWLING

A medical Lawn Bowling Club has been organized in Winnipeg.

Through the courtesy of the Assiniboine Bowling Club, the members bowl each Tuesday at the Assiniboine Bowling Greens at 12.30.

Dr. H. M. Speechly is President and Dr. M. S. Hollenberg the Secretary.

SQUIBB VIOPHATE - D

It has been demonstrated that the most favorable ratio of calcium and phosphorus in the diet for normal growth and bone formation is between 2.00 and 1.00. Within this range the Vitamin D requirements are at a minimum. Increase in the amount of calcium in the diet without a corresponding increase in the amount of phosphorus can cause a progressive decrease in the ash content of bone, a loss which can be prevented only by the addition of Vitamin D. The reverse is also true, both types of the disproportion in the ratio leading to rickets. Hence, both the amount and the ratio of calcium to phosphorus are important.

While a balanced diet may often provide the proper ratio between these two elements, the food likes and dislikes of children and the digestive upsets or unnatural food longings of the pregnant woman or of chronic invalids often militate against dietary regulations.

For these reasons many dentists long have sought a dietary supplement supplying calcium, phosphorus and Vitamin D in optimum amounts to assist in maintaining the metabolic integrity of dental tissues.

Squibb now markets such a product, Viophate-D, both in most palatable wintergreen-flavored wafers and in capsules. Each wafer contains 9 grains Dicalcium Phosphate, 6 grains Calcium Gluconate, together with at least 660 units of Vitamin D. The ratio of calcium to phosphorus is 1.625 to 1. Two capsules are equivalent to one tablet. The suggested prophylactic dose is three tablets or six capsules daily. —Advt.

RAILWAY TICKETS

Extension of Time for Illness

Some little time ago we had correspondence from the Canadian Passenger Association with regard to the increasing number of requests from railway passengers to have the time limit of their railway tickets extended on account of illness. The following paragraph is quoted from that letter:

> The railways have found during the last few months an extraordinary large number of these certificates being presented. In some instances it is quite obvious that the cases are deserving ones, but we do feel that some undue advantage is being taken of this privilege, possibly through humanitarian feelings on the part of the medical men. This has caused considerable embarrassment to both the patients and the railways, and I would ask you to circularize your members, or possibly include an article in your "Journal," asking that every precaution be taken by members of your profession in the signing of such certificates; furthermore that certificates must be filled in full and not simply signed in blank. This is a privilege that is placed in the hands of the medical profession, and we feel that it is only necessary to draw your attention to the necessity of seeing that each and every case is absolutely legitimate and in accordance with the regulations governing this concession.

No doubt all that is necessary is to call the attention of our members to this matter.

> NOTE: The Canadian Passenger Association, Western Lines, desires to inform the medical profession and their patients that, in the territory of Port Arthur to the Pacific Coast, effective June 1st, no extensions will be made on local bargain coach excursion tickets on account of illness.

From the Canadian Medical Association Journal.

Department of Health and Public Welfare

NEWS ITEMS

The following is a copy of an article published in "Preventive Medicine" by the New York Academy of Medicine and written by Doctor Max Seham, Associate Professor of Pediatrics, University of Minnesota Medical School, which we believe to be a timely article now the Holiday Season is beginning:

"REST AND RELAXATION IN THE PREVENTION OF CHRONIC FATIGUE IN CHILDREN"

"The prevention of chronic fatigue cannot be visualized in 'a straight line,' at one end of which is the cause and at the other the effect. The problem is rather comparable to a circle composed of many causative arcs, each of which is equally important and all of which are closely related and mutually interdependent. Although we are wont to classify them as physical or physiologic, emotional, or psychological, in reality they are as inseparable as concave is from convex; they overlap, and they are interchangeable. However, the restriction of this paper prevents a discussion of each of these factors. I have chosen therefore to dwell upon one factor which is all too often taken for granted by the medical profession and is therefore insufficiently stressed to the parents. I refer to the factor of Rest and Relaxation.

"Rest is the physiological state in which activity of the living organs is momentarily suspended or lowered beneath the normal level. It may be absolute or relative, total or partial. Accurately speaking, it is only relative, for the interrelation amongst the various organs does not permit suspension of activity.

"Rest is diametrically opposed to fatigue. During rest, energy renewal and recovery predominate. Rest economizes living materials, fixes more fat in the tissues, and conserves stored energy for unexpected expenditures. It also restores bodily calm and serenity, indices of psycho-biological equilibrium.

"The effects of rest vary with its duration, the importance of that organ or system reduced to inaction, and the rigor with which the body or its parts are immobilized. In general, only to a lesser extent, the same benefits derived from sleep are also obtained through rest.

"When we are fatigued, it is certainly necessary to rest. This very simple truth raises certain questions (1) when is it best to rest? (2) for how long a time should one rest? (3) the practice of rest. There is, then, a science of rest. It is because we have ignored the science that so many people are chronically overtired, not only after fatiguing work, but even when in apparent inertia.

1. When Is the Time to Rest.

"We may rest when fatigue is present, before fatigue comes upon us, or we may persist in working for a certain time in spite of fatigue. The latter suggestion arises from the early writings of James[1] who asked the question: 'Is it legitimate, is it moral, to yield to every sign of weariness. Fatigue may easily become with us a habit, often destructive to legitimate effort. We all have known the perpetually tired man, chronically fatigued, to whom both initiative and performance alike are distasteful and to be avoided whenever possible. This condition may at times be so pronounced as to be positively pathological, demanding special curative treatment. Fortunately, such a condition is rare. Most of us may live on a high or low plane of cativity at will; we may do much or little; we may yield early to fatigue, or we may successfully resist it for a time with impunity.'

"To quote further: 'The human individual lives usually far within his limits; he possesses powers of various sorts which he habitually fails to use. He energizes below his maximum, and he behaves below his optimum. In elementary faculty, in co-ordination, in power of inhibition and control, in every conceivable way, his life is contracted like the field of vision of a hysteric subject—but with less excuse, for the poor hysteric is diseased, while in the rest of us, it is only an inveterate habit—the habit of inferiority to our full self. We live subject to arrest by degrees of fatigue which we have come only from habit to obey. Most of us may learn to push the barriers farther off and to live in perfect comfort on much higher levels of power.'

"What James says is reasonable, especially as applied to the adult. One cannot therefore advocate as a universal law the avoidance altogether of even excessive fatigue. It may well be an advantage to train oneself to resist fatigue. There may be occasions when even a child ought to dig into his or her reserve forces. The physician however must point out that serious damage may result from such habits.

"The child who continues in fatiguing work without intermittent rests is like the peasant who mows when his blunted scythe is no longer able to do more than ruffle the grass which should be cut down. In the child especially, work produced under conditions of nascent fatigue is generally inferior. When fatigue supervenes, and one feels 'he is not getting on well,' it is much better to abandon work. Especially if a large amount of work is to be done, there is an advantage in resting before fatigue appears.

"The effect of a resting period on a single muscle is strikingly shown in a laboratory experiment on an animal. If the muscle be stimulated by a series of gentle electric shocks, the record shows, after a few minutes, a diminution in the extent of the contractions because of fatigue. If then, the stimuli cease, and a rest is allowed, the working power of the muscle is largely restored. The blood has washed out of the tissue the accumulated toxic fatigue substances, has brought to the fatigued cells food and oxygen, and they are prepared again to undertake their labors. In other words, if a muscle is prevented from reaching intense exhaustion by periodic rests, in a given time, it may accomplish a much greater number of contractions than if it had worked without relaxation. In such a case, the intervals devoted to rest are not time lost, but time gained: for example, we exhaust a muscle by making it perform thirty contractions; it needs two hours of rest for complete recovery; but if we had interpolated rest in the middle of the work, that is, after fifteen contractions, half an hour would have sufficed to repair the fatigue produced, and the work done in the second experiment would be superior to that done in the first. In such experiments the conditions of work are exaggerated, but the principle of rest thus illustrated is applicable to the human.

Prescribing Rest.

"In general, the organism knows quite well how to preserve itself from exhaustion; certain spontaneous 'safety factors' come to the rescue when the organism is menaced. These mechanisms are inattention, dislike for the work in hand, and the desire to rest, sleep, or play. The practical means of rest is that of doing nothing. Yet even today so simple and inexpensive a natural curative agent is not granted the respect which it deserves.

"Parents give some heed to a sleep schedule, but there are very few who consider a rest schedule of any practical importance. A great deal can be done to postpone or even prevent fatigue from day to day and hasten daily recovery by systematically sticking

to a schedule. The child of school age can rest twice a day. At noon, every child living in a city has at least fifteen minutes for rest. This can be made more effective by having the child lie on a hard davenport or on the floor with a small pillow under the small of his back. After school, at least thirty minutes can be used for this purpose. If extra treatment for fatigue is needed, these periods can be lengthened. If necessary, another fifteen minutes of rest may be utilized before leaving for school in the morning or before supper. There are many miscellaneous factors which help to secure rest. For instance, the value of a rest pause may be increased by alterations in posture rather than by remaining alert. Walking quietly, or light muscular exercise acts beneficially in modifying temporarily the immediate fatigue; a similar result may ensue from taking light refreshment. Elimination of unnecessary speed, using adjustable chairs and seats, finding the most efficient positions, sitting instead of standing whenever possible; all these points will help in the problem of prevention of fatigue day by day.

"To impress parents with the importance of rest schedules, it is necessary to prescribe formal specific instructions. The instructions must be as stringent as those of medical treatment. For instance, a patient advised to remain in bed often fails to get the desired effects. He may not know how to relax, the restlessness may be increased by distress; he may shift and fidget in bed, or, owing to tense muscles, he may lie stiffly and uncomfortably. These conditions necessitate specific written orders.

"The conditions of rest should naturally be inverse to those which produced the fatigue. The exhaustive activity itself should be reduced or eliminated; extreme haste, worries and undue excitement should be eradicated, supplanted by relative quiet, repose, distraction or diversion, and often a change in the sphere of interest. Rest of the muscles is the first essential, for all the organs tend to be more or less activated according to the tonus of the muscles. In other words the technique of rest depends upon the process of relaxation.

Relaxation.

"Relaxation plus rest best approximate sleep in effectiveness against fatigue. The popular and technical usages of the term relaxation are quite different. Laymen speak of relaxation as synonymous with change of scene, physical culture, and various pleasures. They understand the word to mean diversion or recreation. The use of relaxation as a therapeutic agent in medicine has been for the most part scattered and occasional. Anne Payson Call (1902), a Boston nurse, helped nervous persons to cultivate poise by the use of relaxing exercises. But her interests were practical rather than scientific. Occasionally, suggestion and persuasion have calmed excitable patients; hypnosis has been employed to the same end by a few German physicians. But the credit for taking the subject out of the realm of the popular and the cults, and making of it a scientific and permanent form of treatment belongs to Jacobsen.[2]

"Jacobsen first suspected the importance of relaxation among individuals who, though lying apparently quiet, remained restless and hypertense. They continued to betray signs of mental activity, organic excitement, anxiety or other emotional disturbances; they breathed irregularly, they fidgeted, had restless movements of the eyes, fingers, and other parts of the body. It was evident to him that rest under these circumstances was not complete; following it, the patients often failed to be refreshed. He further observed that 'respiration is slightly irregular in time or force; the pulse rate, although often normal, is in some instances moderately increased as compared with later tests; voluntary or local reflex activities are revealed in such slight marks as wrinkling of the forehead, frowning, movements of the eyeballs, tenseness of muscles about the eyes, frequent or rapid winking, restless shifting of the head, a limb, or even a finger; the knee-jerk and other deep reflexes can be elicited; a reflex start generally follows any sudden unexpected noise; finally, the mind continues to be active, and once started, worry or oppressive emotion will persist.' These signs he designated as 'residual tension,' and accordingly was led to inquire whether the foregoing phenomena would not diminish or disappear if a greater extent of relaxation were cultivated.

"Doing away with residual tension is, then, the essential feature of his method. By the use of his technique, Jacobsen claims to do three things: (1) The patient relaxes a group of muscles, for instance, the biceps-brachial of the right arm, further and further each minute; (2) he learns consecutively to relax the principal muscle groups of his body. With each new group, he simultaneously relaxes such parts as have previously received practice; (3) as he practices from day to day, he progresses toward a habit of repose, tends toward a state in which quiet is automatically maintained. According to Jacobsen, to get curative effects the practice must be repeated over and over again two or more times a day so that the individual can pass within a few minutes from a state of tension or excitement into one of complete relaxation.

"Theoretically, progressive relaxation should be of help for the particular group of disorders which we are discussing. The technique is based upon sound physiological principles of reconditioning the individual through the neuro-muscular system. It serves the needs of the child even more than those of the adult, because in the child these functional disorders are not so beset with the unconscious symptoms of neurosis as in the adult. We believe that Jacobsen's idea applied to children suffering from functional disorders that are chiefly of physiological origin can be made to serve an important role in their prevention and cure. At the present time, those of us who have tried the method in children, have failed probably because we do not understand sufficiently the exact details of his technique. Its trial, however, is recommended.

Summary and Conclusions.

"1. Rest is specific for acute fatigue and exhaustion.

"2. Rest is helpful for chronic fatigue.

"3. Rest decreases the strain on the heart and the blood vessels, and diminishes the energy output and thus also the required caloric intake.

"4. Rest quiets the nervous system, thus tending to relieve excitement, heightened reflexes, and often spastic states.

"5. Rest periods reduce the length of the day, insuring adequate recovery during interspersed intervals, before great fatigue has accumulated. Therefore, rest pauses have been almost universally accepted by industry as aids in increasing production and curtailing fatigue.

"6. In general, as evidenced by numerous experiments, a greater output can be achieved by applying oneself steadily for short periods, and then resting, than by applying oneself less steadily and having no rest periods. The rests should be just long enough to permit recovery from fatigue without losing further time or momentum. There should be a balance between work and rest.

"On the basis of the above conclusions the following outline of prevention is suggested:

"1. Study type of child—his rhythm and manner of work.

"2. Select carefully activities adapted to the child.

"3. Determine most economical methods of work.

"4. Train systematically in methods of work.

"5. Abolish causes of needless resentment, irritation and worries, nervous and emotional tensions.

"6. Introduce suitable incentives to work.

"7. Provide adequate physical environment in regard to illumination, temperature, humidity, and ventilation.

"8. Avoid activity beyond effective limit.

"9. Introduce rest pauses and variations of activities.

"10. Balance work and rest which will give the maximum efficiency.

"11. Provide and carry out adequate schedule of health habits."

1. James, Wm. "Principles of Psychology," H. Holt & Company, 1890, New York.
2. Jacobsen, Edmund. "Progressive Relaxation," University of Chicago Press, 1929.

COMMUNICABLE DISEASES REPORTED

Urban and Rural - May, 1938.

Chickenpox: Total 382—Winnipeg 299, Rosser 13, Kildonan North 10, Roland 8, St. Boniface 8, Kildonan East 5, Flin Flon 4, Kildonan West 4, St. Vital 4, Portage Rural 2, Brandon 1, St. Andrews 1, St. James 1, Transcona 1, Woodlands 1 (Late Reported: April, Kildonan North 19, Kildonan West 1).

Mumps: Total 289—Winnipeg 169, Brandon 74, St. James 10, St. Vital 8, Ethelbert 2, Kildonan East 2, Transcona 2, Sifton 1, The Pas 1 (Late Reported: April, Brandon 15, St. James 5).

Whooping Cough: Total 90—Brandon 33, Winnipeg 22, Flin Flon 3, St. Vital 3, Transcona 3, Portage City 2, Roblin Village 2, Unorganized 2 (Late Reported: April, Brandon 13, St. Vital 4, Kildonan East 2, Flin Flon 1).

Scarlet Fever: Total 89—Winnipeg 33, Unorganized 7, Brandon 6, Springfield 6, Franklin 5, Macdonald 3, Daly 2, Portage City 2, Roblin Village 2, Shell River 2, Brokenhead 1, Cameron 1, Hanover 1, Kildonan East 1, Melita 1, Pipestone 1, Rockwood 1, St. Francois 1, St. James 1, St. Vital 1, Victoria Beach 1 (Late Reported: February, Beausejour 1; April, Unorganized 3, Riverside 2, Kildonan East 1, Portage City 1, Thompson 1, Saskatchewan 1).

Tuberculosis: Total 49—Unorganized 8, Winnipeg 6, Eriksdale 3, St. James 3, Grandview Town 2, Roblin Rural 2, Strathcona 2, St. Boniface 2, St. Vital 2, Armstrong 1, Brandon 1, Brokenhead 1, Cartier 1, Dauphin Town 1, DeSalaberry 1, Dufferin 1, Ethelbert 1, Flin Flon 1, Gimli Town 1, Grey 1, Harrison 1, Portage City 1, Portage Rural 1, Rhineland 1, Swan River Town 1, St. Clements 1, St. Laurent 1, Woodlea 1.

Measles: Total 46—Rhineland 19, Portage Rural 16, Winnipeg 4, Roblin Rural 3, Roblin Village 2, St. Vital 1 (Late Reported: February, Rosedale 1).

Typhoid Fever: Total 11—Unorganized 6, Birtle Town 1, Fort Garry 1, Russell Rural 1, Shellmouth 1, Winnipeg 1.

Influenza: Total 17—Winnipeg 2 (Late Reported: March, Montcalm 2, Cameron 1, Charleswood 1, Coldwell 1, Cypress South 1, Ethelbert 1, Flin Flon 1, Gimli Town 1, South Norfolk 1, Roblin Rural 1, Winnipegosis 1, Unorganized 2; April, Unorganized 1).

Erysipelas: Total 10—Winnipeg 6, Argyle 1, Roblin Rural 1, The Pas 1, Westbourne 1.

Diphtheria: Total 10—Winnipeg 7, Ste. Anne 1, St. Vital 1, Unorganized 1.

Smallpox: Total 8—Minto 8.

Ophthalmia Neonatorum: Total 4—Winnipeg 2, Shoal Lake Village 1, St. James 1.

Trachoma: Total 2—Winnipegosis 1, Winnipeg 1.

Anterior Poliomyelitis: Total 1—Winnipeg 1.

Puerperal Fever: Total 1—(Late Reported: March, Brandon 1).

Septic Sore Throat: Total 1—Rapid City 1.

Venereal Diseases Reported: Total 102—Gonorrhoea 60, Syphilis 42.

DEATHS FROM ALL CAUSES IN MANITOBA

For the Month of April, 1938.

URBAN—Cancer 39, Pneumonia (all forms) 12, Tuberculosis 9, Diphtheria 1, Influenza 1, Erysipelas 1, Syphilis 1, all others under 1 year 22, all other causes 160, Stillbirths 13. Total 259.

RURAL—Pneumonia 23, Cancer 21, Tuberculosis 17, Influenza 11, Typhoid Fever 1, all others under 1 year 16, all other causes 136, Stillbirths 11. Total 236.

INDIAN—Tuberculosis 4, Pneumonia 3, Cancer 2, all others under 1 year 2, all other causes 3. Total 14.

Medical Library University of Manitoba

Current Medical Literature

"The American Journal of Obstetrics and Gynecology"—January, 1938.

"Theca Cell Tumors," by Samuel H. Geist, M.D., and Joseph A. Gaines, M.D., New York, N.Y. (From the Gynecological Service and Department of Laboratories, Mount Sinai Hospital).

"Disease of the Spinal Cord in Pregnancy: Myelopathy of Pregnancy, A Clinicopathologic Study," by William Needles, M.D., and Charles Davison, M.D., New York. (From the Neuropathological Laboratory and the Neurological Division, the Montefiore Hospital).

"Functional Uterine Bleeding with Special Reference to that Associated with Secretary Endometrium," by Howard W. Jones, M.D., Baltimore, Md. (From the Department of Gynecology of the John Hopkins Hospital and University).

"Biology of the Human Vagina in Pregnancy," by M. Edward Davis, M.D., and S. A. Pearl, M.D., Chicago, Ill. (From the Department of Obstetrics and Gynecology, The University of Chicago and The Chicago Lying-in Hospital).

"Indentification of Yeastlike Organisms Isolated from the Vaginal Tracts of Pregnant and Non-Pregnant Women," by Claudius P. Jones and Donald S. Martin, M.D., Durham, N.C. (From the Department of Obstetrics and Gynecology and the Department of Bacteriology, Duke University Medical School).

"The Blood Picture of Pregnancy," by H. G. Watson, M.D., San Francisco, Calif. (From the Department of Obstetrics and Gynecology, University of California Medical School).

"The Quantitative Determination of Estrogenic Substances in Normal Female Urine During the Menstrual Cycle," by R. G. Gustavson, Ph.D., Lyman W. Mason, M.D., Edwin E. Hays, B.S., Thomas R. Wood, B.S., and F. E. D'Amour, Ph.D., Denver, Colo. (From the Research Laboratories of the University of Denver).

"A Study of 285 Cases of Breech Delivery," by W. C. Danforth, B.S., M.D., F.A.C.S., and Charles Edwin Galloway, B.S., M.D., F.A.C.S., Evanston, Ill. (From the Department of Obstetrics and Gynecology of Northwestern University Medical School and of the Evanston Hospital).

"Prolongation of Pregnancy in the Rabbit by the Injection of Progesterone," by George P. Heckel,

M.D., and Willard M. Allen, M.D., Rochester, N.Y. (From the Departments of Obstetrics and Gynecology and of Anatomy, The University of Rochester, School of Medicine and Dentistry).

"Quinine Iodobismuthate in the Treatment of Syphilis Complicating Pregnancy," by Mario A. Castallo, M.D., and A. E. Rakoff, A.B., M.D., Philadelphia, Pa. (From the Department of Obstetrics, Jefferson Medical College Hospital).

"Short-Wave Therapy in Gynecology and Obstetrics: Experiences with One Hundred Twenty Cases," by Edward G. Waters, M.D., Ph.B., F.A.C.S., Jersey City, N.J. (From the Margaret Hague Maternity Hospital).

"Postpartum Hypertension Following a Normal Pregnancy," by Harry Meyer, M.D., New Orleans, La. (From the Obstetrical Out-Patient Department of Touro Infirmary).

"The Basal Metabolic Rate in Normal Pregnancy," by George Carson Hanna, Jr., M.D., Philadelphia, Pa. (Kensington Hospital for Women).

"A Superimposed Lipemia During Labor," by Eldon M. Boyd, M.A., M.D., and Gordon Mylks, Jr., A.B., M.D., Kingston, Ont. (From the Department of Obstetrics, Queen's University).

"Myxedema with Menorrhagia and Tetany as Complications Following a Partial Thyroidectomy," by Charles W. Dunn, M.D., and William R. Nicholson, M.D., Philadelphia, Pa.

"A Lateral Vaginal Wall Retractor," by Monte C. Piper, M.D., Rochester, Minn. (From the Section on Obstetrics and Gynecology, The Mayo Clinic).

"The Clinical Journal"—April, 1938.

"Carcinoma of the Tongue," by A. J. Gardham, M.S., F.R.C.S., Assistant Surgeon, University College Hospital, Surgeon to Out-Patients, Hampstead General Hospital.

"Thrombosis of the Peripheral Veins of Visceral Cancer," by A. P. Thomson, M.C., M.D., F.R.C.P., Honorary Physician to the General Hospital, Birmingham.

"The Non-Medical Treatment of Osteo and Rheumatoid Arthritis," by R. Broomhead, F.R.C.S., Hon. Surgeon, Orthopaedic Department, General Infirmary, Leeds; Lecturer in Orthopaedic Surgery, University of Leeds.

"Pyrexia of Uncertain Origin," by Ronald E. Smith, M.B., M.R.C.P., Medical Officer of Rugby School.

"The Treatment of Obesity," by R. E. Tunbridge, M.D., M.Sc., M.R.C.P., Reader in Medicine, The University of Leeds; Hon. Physician, Leeds Public Dispensary and Hospital.

"Cullen's Sign in a Case of Antepartum Rupture of a Caesarean Section Scar," by E. A. Gerrard, M.D., M.C., O.G., Honorary Assistant Obstetric Surgeon, St. Mary's Hospitals, Manchester; Assistant Lecturer in Obstetrics and Gynaecology, Manchester University.

"The Role of Radiology in the Early Diagnosis and Treatment of Hypernephroma and Other Renal Tumours," by Humphrey Fox, M.R.C.S., Formerly Senior Assistant Medical Officer, Radiological Department, Manchester Royal Infirmary.

"Australian and New Zealand Journal of Surgery"—October, 1937.

"The Hamilton Russell Memorial Lecture: The Physiology of Acute Circulatory Failure Due to Haemorrhage and Shock," by Sir Stanton Hicks, Professor of Human Physiology and Pharmacology, University of Adelaide.

"Therapy by Radium and X-Rays," by R. Douglas Wright, Pathology Department, University of Melbourne.

"Sidelights on Disease of the Prostate Gland," by Chas. M. Greenslade, Dunedin.

"Gas Keratitis," by W. A. Fairclough, Auckland.